PRACTITIONER OF RESPIRATORY CARE
APPLICATION FOR REINSTATEMENT OF REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Date Received by Board

License No._____

File No._____

1105 Terminal Way, Ste 301, Reno, Nevada 89502 Phone (775) 688-2559 (For Board Use Only)

I hereby apply for reinstatement of biennial registration and enclose the appropriate fee as indicated below:

_____REINSTATEMENT FEE $400.00

For the Biennial Registration Period March 1, 2010 – February 29, 2012

Name: _____

Address: _____

_____

Phone: _____

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

- **YOUR CURRENT LICENSE TO PROVIDE RESPIRATORY CARE SERVICES EXPIRES ON FEBRUARY 28, 2010. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY MARCH 1, 2010 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD.**
- **YOUR LICENSE WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY
PLEASE PROVIDE ALL INFORMATION AS REQUESTED

1. Your application for Reinstatement of Registration of License requires the submission of proof of current certification by the National Board for Respiratory Care **AND** 20 contact hours of continuing professional education (CE) as described in NAC 630.530(3)(a) completed during the preceding 24-month time period of the date of your submission of this form.

2. If your name and/or address has changed, clearly indicate the change in the space provided below. Please be advised, the address you indicate below is viewable on the NSBME website and is listed as the "public" address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

Email address_____

Indicate below your primary and secondary scope of practice specialties using the following codes:

SCOPE OF PRACTICE SPECIALTY CODES

1	GENERAL FLOOR CARE	6	PULMONARY REHABILIATION / CARDIAC REHABILITATION
2	EMERGENCY / CRITICAL CARE / TRAUMA	7	PERINATAL / PEDIATRIC
3	SLEEP DISORDERS	8	HOME CARE
4	PULMONARY FUNCTION TESTING	9	HOME MEDICAL EQUIPMENT
5	MANAGEMENT	10	FLIGHT MEDICINE

Code **Code**

Primary Specialty _____ **Secondary Specialty** _____

All of the following questions refer to the preceding 24-month time period of the date of your submission of this form or since your last renewal.

For the purposes of the following questions, these phrases or words have these meanings:

"Medical condition" includes physiological, mental or psychological condition or disorders.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you currently have a medical condition that in any way impairs or limits your ability to provide respiratory care services with reasonable skill and safety? _____Yes_____No

2. If you currently have a medical condition which in any way impairs or limits your ability to provide respiratory care services, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes_____No_____N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to provide respiratory care services with reasonable skill and safety? _____Yes _____No_____N/A

4. Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? _____Yes _____No

5. Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? _____Yes _____No

6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal or expungement.
_____Yes_____No

7. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in questions #6? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal or expungement. _____Yes_____No

8. Have you been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? _____Yes _____No

9. Have you had a certificate or license to provide respiratory care services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes_____No

10. Have you EVER voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory? _____Yes_____No

11. Have you EVER failed the National Board of Respiratory Care examination, or any state or other jurisdiction examination for certification, licensure or registration as a practitioner of respiratory care? _____Yes_____No

12. Have you EVER had your registration/certification revoked, suspended and/or limited by the National Board of Respiratory Care? _____Yes_____No

13. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a provider of respiratory care by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____Yes_____No

14. Have you practiced as a practitioner of respiratory care in the state of Nevada in the past 24 months? _____Yes_____No

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CERTIFICATION STATEMENT

I am currently certified by the National Board for Respiratory Care.

- **ATTACH COPY OF PROOF OF YOUR CURRENT CERTIFICATION.**
  (YOUR COPY OF PROOF OF CURRENT CERTIFICATION WILL NOT BE RETURNED TO YOU.)

CONTINUING PROFESSIONAL EDUCATION (CE) STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I completed a minimum of 20 contact hours of continuing professional education (CE), 2 hours of which were in ethics, during the past biennial period of March 1, 2008 through February 28, 2010, as described in NAC 630.530(3)(a);
_____ (b) I was initially licensed in Nevada during the time period September 1, 2008 through February 28, 2009, the second six months of the past biennial period, and completed a minimum of 15 contact hours of continuing professional education (CE), 2 hours of which were in ethics, as described in NAC 630.530(3)(b);
_____ (c) I was initially licensed in Nevada during the time period March 1, 2009 through August 31, 2009, the third six months of the past biennial period, and completed a minimum of 10 contact hours of continuing professional education (CE), 2 hours of which were in ethics, as described in NAC 630. 530(3)(c); **OR**
_____ (d) I was initially licensed in Nevada during the time period September 1, 2009 through February 28, 2010, the fourth six months of the past biennial period, and completed a minimum of 5 contact hours of continuing professional education (CE), 2 hours of which were in ethics, as described in NAC 630. 530(3)(d).

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING PROFESSIONAL EDUCATION (CE) HOURS.**

- **YOUR COPIES OF PROOF OF CE COMPLETION WILL NOT BE RETURNED TO YOU.**
  FOR A CURRENT LIST OF APPROVED CONTINUING PROFESSIONAL EDUCATION SOURCES, YOU MAY VISIT OUR WEBSITE AT www.medboard.nv.gov AND CLICK THE "CONTINUING EDUCATION REQUIREMENTS FOR PRACTITIONER OF RESPIRATORY CARE LICENSE RENEWAL (NAC 630.530) BUTTON.

HOME ADDRESS & PHONE NUMBER *(REQUIRED)*

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION* OF LICENSE TO PROVIDE RESPIRATORY CARE SERVICES IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**

2) **I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**

3) **I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S) AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING PROFESSIONAL EDUCATION (CE); (b) THE APPROPRIATE PROOF OF CURRENT CERTIFICATION BY THE NATIONAL BOARD FOR RESPIRATORY CARE; (c) PAYMENT OF THE $250.00 REGISTRATION RENEWAL FEE; AND (d) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

_____ _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**